(e)(3) of this section on a service-area-specific basis.

(f) *Rules for dependents*—(1) *General rule.* If an eligible individual elects to enroll in individual health insurance coverage that provides coverage for dependents, the issuer may apply a preexisting condition exclusion on any dependent who is not an eligible individual.

(2) *Exception for certain children.* A child is deemed to be an eligible individual if the following conditions are met:

(i) The child was covered under any creditable coverage within 30 days of birth, adoption, or placement for adoption (or longer if the State provides for a longer special enrollment period than required under §146.117(a)(6) of this subchapter).

(ii) The child has not had a significant break in coverage.

(3) *Examples.* The following examples illustrate the requirements of this paragraph (f) for certain children:

Example 1: Individual *A* had self-only coverage under his employer's group health plan for five years. *A* has two children, ages 11 and 15, but never enrolled in family coverage. *A* leaves his job to become self-employed, and qualifies as an eligible individual because he is not entitled to any continuation coverage, Medicare or Medicaid, and has no other health insurance coverage. He applies to Issuer *R* for coverage in the individual market under a policy with family coverage that *R* makes available to eligible individuals. *R* must sell *A* the policy, but he may refuse coverage to *A*'s children, or may apply a preexisting condition exclusion to them if allowed under applicable State law, because they did not have prior creditable coverage, and therefore do not qualify as eligible individuals.

Example 2: Individual *B* was also covered under a group health plan for 5 years before losing his job. He originally had coverage only for himself and his wife, but 3 months before his employment ended, his wife had a baby. *B* took advantage of the special enrollment period that applied, changed to family coverage, and enrolled the baby in the group health plan within 20 days. Immediately after losing his job, *B* applied to Issuer *R* for family coverage. *B* and his wife qualify as eligible individuals, and the baby is deemed to be an eligible individual even though she has less than 3 months of creditable coverage. Therefore *R* must make the policy available to all three members of the family, and cannot impose any preexisting condition exclusions.

(g) *Clarification of applicability.* (1) An issuer in the individual market is not required to offer a family coverage option with any policy form.

(2) An issuer offering health insurance coverage only in connection with group health plans, or only through one or more bona fide associations, or both, is not required to offer that type of coverage in the individual market.

(3) An issuer offering health insurance coverage in connection with a group health plan is not deemed to be a health insurance issuer offering individual health insurance coverage solely because the issuer offers a conversion policy.

(4) This section does not restrict the amount of the premium rates that an issuer may charge an individual under State law for health insurance coverage provided in the individual market.

(5) This section does not prevent an issuer offering health insurance coverage in the individual market from establishing premium discounts or rebates, or modifying otherwise applicable copayments or deductibles, in return for adherence to programs of health promotion and disease prevention.

(6) This section does not require issuers to reopen blocks of business closed under applicable State law.

(Approved by the Office of Management and Budget under control number 0938–0703)

[62 FR 16996, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 148.122 Guaranteed renewability of individual health insurance coverage.

(a) *Applicability.* This section applies to all health insurance coverage in the individual market.

(b) *General rules.* (1) Except as provided in paragraph (c) of this section, an issuer must renew or continue in force the coverage at the option of the individual.

(2) Medicare eligibility or entitlement is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market.

(c) *Exceptions to renewing coverage.* An issuer may nonrenew or discontinue

health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) *Nonpayment of premiums.* The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

(2) *Fraud.* The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) *Termination of plan.* The issuer is ceasing to offer coverage in the individual market in accordance with paragraphs (d) and (e) of this section and applicable State law.

(4) *Movement outside the service area.* For network plans, the individual no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(5) *Association membership ceases.* For coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(d) *Discontinuing a particular type of coverage.* An issuer may discontinue offering a particular type of health insurance coverage offered in the individual market only if it meets the following requirements:

(1) Provides notice in writing to each individual provided coverage of that type of health insurance at least 90 days before the date the coverage will be discontinued.

(2) Offers to each covered individual, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in that market.

(3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(e) *Discontinuing all coverage.* An issuer may discontinue offering all health insurance coverage in the individual market in a State only if it meets the following requirements.

(1) Provides notice in writing to the applicable State authority and to each individual of the discontinuation at least 180 days before the date the coverage will expire.

(2) Discontinues and does not renew all health insurance policies it issues or delivers for issuance in the State in the individual market.

(3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(f) *Prohibition on market reentry.* An issuer who elects to discontinue offering all health insurance coverage under paragraph (e) of this section may not issue coverage in the market and State involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

(g) *Exception for uniform modification of coverage.* An issuer may, only at the time of coverage renewal, modify the health insurance coverage for a policy form offered in the individual market if the modification is consistent with State law and is effective uniformly for all individuals with that policy form.

(h) *Application to coverage offered only through associations.* In the case of health insurance coverage that is made available by a health insurance issuer in the individual market only through one or more associations, any reference in this section to an ''individual'' is deemed to include a reference to the association of which the individual is a member.

(Approved by the Office of Management and Budget under control number 0938–0703)

[62 FR 16998, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 148.124 Certification and disclosure of coverage.

(a) *Applicability*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, this section applies to all issuers of health insurance coverage.

(2) *Exception.* The provisions of this section do not apply to issuers of the following types of coverage: